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#85 HEALTH INDUSTRY LABOR Reports

STATE OF NEW YORK DEPARTMENT OF HEALTH

CORNING TOWER • THE GOVERNOR NELSON A. ROCKEFELLER EMPIRE STATE PLAZA • ALBANY, N.Y. 12237

DAVID AXELROD, M.D.
Commissioner

LORNA McBARNETTE
Executive Deputy Commissioner

March 29, 1988

Juanita K. Hunter, R.N., Ed.D
President
New York State Nurses Association
2113 Western Avenue
Guilderland, New York 12084

Dear Dr. Hunter:

Attached for your review and consideration is a copy of the preliminary report of the Labor-Health Industry Task Force on Health Personnel.

In addition, as we discussed at the Nursing Shortage Discussion Workshop of March 16, 1988 sponsored by Assemblyman Kenneth LaValle and Senator Tarky Lombardi, I am sending you the following materials:

- as Attachment 1, a news bulletin entitled "Urgent Nursing Alert" which appeared in District Association Newsletters.
- as Attachment 2, page 1 of the article entitled "Task Force Offers Scholarships - and Insults", the Jan-Feb 1988 NYSNA Newsletter.

In order for us to effectively address the health personnel shortages we are experiencing, it is critical that we make a cooperative and collaborative effort. It is my hope that in the future we can work together to implement the recommendations of the task force.

I look forward to hearing from you on this matter.

Sincerely,

Lorna McBarnette

Lorna McBarnette
Executive Deputy Commissioner
Office of the Commissioner

ATTACHMENT 1

Urgent Nursing Alert

The New York State Health Department's Labor-Health Industry Task Force on Health Personnel contains recommendations that are unfavorable to consumers of health care and to the long-term resolution of professional issues.

It is imperative that you write to the Governor and your legislators expressing your concern about the report and directing their attention to more constructive solutions.

The problems with the recommendations include:

Allowing professional functions to be determined by institutions rather than practice acts, codes rules and regulations which negates protection of the public through common standards of care.

Revision of the Nurse Practice Act.

Reducing standards for entry into the profession including a suggested provision for challenging professional licensure exams.

Further, the Task Force is proceeding on erroneous assumptions, i.e., no present career ladders in the field, no articulation between educational programs, few efforts by healthcare institutions to cut costs, etc. Much documentation to the contrary is available.

Point out that enhancement of the image of the profession, education of guidance counsellors and others in a position of influence, tapping other sources such as "second-career people", males and the "returning to the work force" woman, scholarships with financial incentives to stay in hospital, long-term care and other settings are all viable options.

State that educational standards cannot be lowered, both for the protection of the consumer and for the enhancement of respect for the profession. Accelerated and financially supportive measures are possible without a compromise in quality.

Stress that nursing is not a collection of functions, but is a knowledge-based profession devoted to patient assessment, intervention, evaluation and reassessment and because legislators believe the profession is not well-defined, use specific words to describe nursing that relate to the definition in the Nurse Practice Act ("diagnosing and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counselling, and the provision of care supportive to or restorative of life and well-being.") Then we will all be speaking the same language.

State that examination of reimbursement needs to continue to ensure quality of care and support for the nursing profession. Suggest also that the cost effectiveness, cost benefit ratio of regulations and their interpretation require intense examination to determine which ones are actually supportive to quality and maintenance of standards and which divert professional activity away from care giving.

Governor Mario Cuomo
Office of the Governor
New York State Capital
Albany, NY 12224

Assemblymen

Paul D. Tonko
District #105, Room 725 CAP
Montgomery, Schenectady, Albany & Schoharie Counties

Michael R. McNulty
District #106, Room 636 LOB
Rensselaer and Albany Counties

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...mblymen (continued)

...eld W. Proskin
...rict #103, Room 725 LOB
...y and Saratoga Counties

...rd J. Conners
...rict #104, Room 524 CAP
...y County

...W. Kelleher
...rict #100, Room 320 LOB
...ington, Rensselaer & Warren Counties

...ters

...T. Farley
...ict #44, Room 706 LOB
...ectady, Montgomery, Fulton, Hamilton & Saratoga Counties

...th L. Bruno
...ict #43, Room 914 LOB
...laer, Saratoga & Columbia Counties

John Faso
District #102, Room 448 LOB
Greene, Columbia & Albany Counties

James Tedisco
District #107, Room 530 LOB
Schenectady County

Glenn E. Warren
District #99, Room 527 LOB
Columbia, Rensselaer & Dutchess Counties

Howard C. Nolan, Jr.
District #42, Room 711B LOB
Albany County

Jay P. Rolison, Jr.
District #41, Room 512 LOB
Dutchess & Columbia Counties

Ronald B. Stafford
District #45, Room 502 CAP
Warren, Washington, Essex, Clinton, Franklin & St. Lawrence Counties

...SE NOTE: Enclosed in this newsletter is a pull-out letter to Governor Cuomo. If you choose to send ...tter, please don't forget to put a date, an inside-address and a signature on the letter. Correspondence to our ...s counts more when they know who the individual is that is addressing an issue.

Please do it today!!!

...'S HEALTH FAIR - Capital District #9 and the staff of NYSNA will be participating in ...nnual Health Fair at Clifton Country Mall on April 8th and 9th from 4 - 9 Friday and ...5 Saturday. This event is sponsored by the Shenendehowa Lion's Club of Clifton Park. This project is the beginning of this year's effort to effort to reach out to the ...us communities of the district. (The Speaker's Bureau is another project being ...oped.) It is our goal to publicize the opportunities in nursing in the various ...tice settings.

If you can spare an hour or more, please call Sharon Aronovitch at 439-0324. Your ...cipation will be greatly appreciated. If you have never participated in a Health ..., we are sure that you will find it a very worthwhile and enjoyable time. Please ...der helping us and making this project a success!

* * * * * * * *

...FROM DISTRICT #9 RETIRED NURSES: We have received a list of retired nurses in ...ict #9 who are members of NYSNA. Unfortunately, we have no way of tracking retired ...ict-only members. If there is significant interest, we plan to form a retired nurses ... If you'd like to join please contact Jeanne Elisha at 273-5588 (evenings).

... also note: Rides will be made available to dinner/program meetings for retired ...s. If you are retired and would like to attend a meeting and need a ride, please ...Christine Pakatar at 283-5987.

Governor Mario Cuomo
Office of the Governor
New York State Capital
Albany, NY 12224

Dear Governor Cuomo:

I am writing to you to express concern about the New York State Health Department's Labor-Health Industry Task Force on Health Personnel. Although I have not seen a report, verbal discussion in the community indicates that many public safeguards would be removed if the recommendations were to be followed.

Although I am concerned about the "crisis in healthcare" and the problem of nurse recruitment and retention specifically, I think a "quick fix" is inappropriate and will be detrimental in the long run. I understand that thought is being given to allow individuals, other than healthcare professionals, to perform functions for which they are not qualified, whether by education and/or licensure and that professional licensing exams may be offered to those who have not benefitted from a standardized basic educational curriculum.

Further, model demonstration projects which could have some value, may be so unrestricted as to negate the protection of the public through common standards of care.

I do not see, either, how adjustments of the Nurse Practice Act will have an impact on the situation.

Instead, I would prefer to see New York State's valuable resources utilized to change the hospital reimbursement system to facilitate appropriate salaries and benefits for healthcare personnel, to examine the possibility of accellerated educational programs without a compromise in basic minimal standards and to work with the State Education Department, Guidance Counsellors and others to recruit persons into nursing and the other healthcare professions.

Please contact me if you wish further discussion and thank you for the opportunity to comment.

Sincerely,

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ATTACHMENT 2

Unfortunately, other so-called solutions to the nursing shortage are being proposed that represent an attack on the profession and a serious threat to quality health care (see stories below). Some of these "solutions," like several being put forward by the Health Department's Labor-Health Industry Task Force, do not seem alarming at first. For example, the task force recommends "career ladders." Don't be fooled. These ladders are *not* for RNs. They are ladders enabling others to *function* as RNs without the necessary educational preparation. NYSNA is monitoring all such recommendations and working to forestall what is clearly an attack on professional nursing. This is a critical time. You, as professional nurses, may soon be asked to take a more active role in defending the profession and the general public against short-sighted and extremely unwise policies.

Task Force Offers

SCHOLARSHIPS — and INSULTS

A report from the New York State Health Department Labor-Health Industry Task Force on Health Personnel (due for release in February) will probably contain some good news for the nursing profession, and some bad news.

The good news is that the report is expected to recommend:
(a) increased scholarship aid for nursing students,
(b) strategies to improve compensation and benefits for experienced nurses,
(c) prescriptive privileges for appropriately-prepared nurses.

The bad news is that although NYSNA participated in this task force and made a concerted effort to influence its conclusions, the last draft available at press time contains several recommendations detrimental to both the public good and the nursing profession. The recommendations NYSNA objects to are:
(a) A proposal for demonstration projects allowing health care institutions to use licensed health care personnel with "greater flexibility." The exact nature of these projects is still unclear. But the Association believes this recommendation could foster institutional licensure, a practice that undermines common standards for quality care and puts a license in the hands of the institution rather than in the hands of the professional practitioner.
(b) A proposal to allow periodic reassessment of scope of practice requirements and other regulations seen as "barriers" to the utilization of health professionals. This could lead to the sunsetting of the Nurse Practice Act.

Throughout the report, educational standards are referred to as "artificial barriers," and the professional association's concerns for maintaining quality care are disparagingly referred to as "guild interests." In fact, the entire report demeans the profession of nursing.

Open hearings on the recommendations of the Labor-Health Task Force are being considered and may be held around the state. If so, nurses should take advantage of the opportunity to testify on behalf of standards that assure quality care.

NYS Health Department Defies Nursing Experts

Despite strenuous objections by NYSNA and the State Board for Nursing, New York State, on the recommendation of Commissioner of Health David Axelrod, has instituted new regulations permitting LPNs to administer total parenteral nutrition/hyperalimentation, and to flush intermittent intravenous devices even when central venous lines are involved.

These procedures, which according to the State Board for Nursing, require complex judgement and assessment skills, are not within the legal scope of practice of LPNs. Therefore, any registered nurse who permits an LPN under her supervision to perform such procedures will be violating the NYS Nurse Practice Act and can be brought up for disciplinary charges by the State Board for Nursing.

This action by the Health Department represents a serious threat to patient safety and puts registered nurses in an impossible situation, caught between the conflicting dictates of the Department of Health and the State Board for Nursing.

In the course of explaining this bizarre situation to its own members, the Hospital Association of New York (HANYS) advised those who were considering employing LPNs in an expanded capacity "to consult legal counsel before acting."

NYSNA is exploring the ramifications of the conflict, and preparing to take legal action to protect the practice of registered nurses and to assure that New Yorkers will receive appropriate health care from qualified practitioners.

INSIDE...

AIDS and Nursing
A Special Report
• CDC Guidelines
• Nurses Talk About Caring For AIDS Patients
Pages 4-5

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Vol. 81(7)

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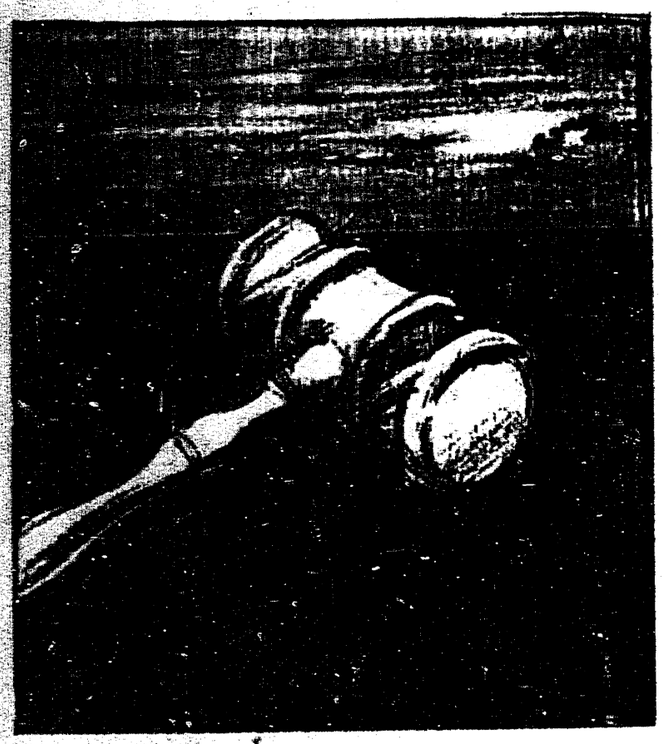
Sunset Laws



By Susan J. Grobe

Within a few short years, the boards of examiners in many of the 35 states that have enacted sunset statutes will face the special challenge of sunset review. How they meet this challenge may chart the course for licensure of nurses and the regulation of nursing practice.

A sunset statute establishes an evaluative review cycle for examining state agencies. If, after review, a state agency or board no longer seems to serve the statutorily designated functions or it no longer serves in the public interest, the agency or its authorizing statute may be altered or abolished.

"Sunset" has a unique mechanism which underscores a seriousness of intent. For an agency to continue to exist after review, it must be recreated by legislative action. If legislative action does not follow the review, the sun is allowed to set on the agency.

According to its proponents, sunset review is a process that makes governmental agencies more accountable to those it governs(1). The legislative reenactment provision of sunset statutes, however, introduces interesting political possibilities.

Alterations in either the board or the practice act may be made during the legislative reenactment portion of the review cycle. Thus, it is conceivable that both the composition of a state's board of nurse examiners and a state's nurse practice act may, with very little warning, be changed during the review.

It is important that individual nurses be familiar with their state's sunset statute, including the legislative and political processes affecting review, since it may be necessary for them to speak on behalf of the board and the nurse practice act.

Review Process

Each state legislature designs and enacts its own sunset statute, called "legislative oversight statute" in some states. The state's statute details both the criteria and the timetable for the conduct of the review process.

Principles. A state's statute can include any or all of the following 10 principles presented by John Gardner of Common Cause in his 1976 testimony in support of federal sunset legislation.

First: The programs or agencies covered under the law should automatically terminate on a certain date, unless affirmatively recreated by law.

Second: Termination should be periodic (e.g., every six or eight years) in order to institutionalize the process of reevaluation.

Third: Like all significant innovations, introduction of the sunset mechanism will be a learning process and should be phased in gradually, beginning with those programs to which it seems most applicable.

Fourth: Programs and agencies in the same policy area should be reviewed simultaneously in order to encourage consolidation and responsible pruning.

Fifth: Consideration by the relevant legislative committees must be preceded by competent and thorough preliminary studies.

Sixth: Existing bodies (e.g., the executive agencies . . .) should undertake the preliminary program evaluation work, but their evaluation capacities must be strengthened.

Seventh: Substantial committee reorganization, including adoption of a system of rotation of [Sunset] committee members, is a prerequisite to effective Sunset oversight.

Eighth: In order to facilitate review, the Sunset proposal should establish general criteria to guide the evaluation process.

Ninth: Safeguards must be built into the Sunset mechanism to guard against arbitrary [agency] termination and to provide for outstanding agency obligations and displaced agency personnel.

Tenth: Public participation in the form of public access to information and public hearings is an essential part of the Sunset process(2).

An individual nurse can find

Texas Sunset Review: The Law And How It Was Applied

Art. 5429k Sunset Act

Short title

Sec. 1.01. This Act may be cited as the Texas Sunset Act.

Definitions

Sec. 1.02. Defines state agency and other terms used in the act.

Sunset advisory commission

Sec. 1.03. Defines who are members of the commission, how they are appointed, how long they serve, and what their responsibilities are.

Staff

Sec. 1.04. Identifies who shall staff the commission.

Report on advisory committee

Sec. 1.05. Calls for July 30 as date for annual agency report to secretary of state.

Agency report to commission

Sec. 1.06. Before September 1 of the odd-numbered year before the year a state agency is abolished according to this Act, the agency shall report to the commission.

Commission duties

Sec. 1.07. Before June 1 of the even-numbered year before the year a state agency and its advisory committees are abolished according to this Act, the commission shall:

(1) review and take action necessary to verify the records submitted by the agency;

(2) conduct a performance evaluation of the agency . . . and prepare a written report, which is a public record.

Public hearings

Sec. 1.08. Between June 1 and November 1 of the calendar year before the year a state agency and its advisory committees are abolished according to this Act, the commission shall conduct public hearings.

Commission report

Sec. 1.09. Before December 15 of the calendar year before the year a state agency and its advisory committees are abolished according to this Act, the commission shall present to the legislature and the governor a report on the agency and its advisory committees.

Criteria for review

Sec. 1.10. The staff and the commission shall consider the following criteria in determining whether a public need exists for the continuation of a state agency or its advisory committees or for the performance of the functions of the agency or its advisory committees:

(1) the efficiency with which the agency or advisory committee operates;

(2) an identification of the objectives intended for

The Texas experience with sunset provides one example of how the review actually proceeds. The Texas Sunset Act established a 12-year timetable for review of selected regulatory agencies beginning January 1, 1977.[3] The Board of Nurse Examiners for the State of Texas was scheduled for review during 1979.

• **October 1979.** A self-evaluation report was completed by the Texas Board of Nurse Examiners and submitted to the evaluation staff of the Sunset Advisory Commission. The evaluative staff reviewed the report, gathered information about the regulation of nursing in other states, and formulated recommendations for the Sunset Advisory Commission. The report of the evaluative staff began, "There is a continuing need to license and regulate the profession from the standpoint of public protection."

Prefacing their report with the statement, "... the following modifications would result in more effective regulation of professional nurses," the evaluative staff recommended that legislation:

a) provide for the appointment of public members to the board;

b) authorize staggered biennial license renewal;

c) provide for license renewals with a late renewal penalty;

d) de-emphasize the examination process;

e) [delete] statutory references to a specific minimum passing grade on the licensure exam;

f) modify licensure prerequisites and grounds for disciplinary action to include only those to which the board can apply a clear objective standard;

g) amend the statute to permit the board to grant variances;

h) require that licensees wishing to reactivate their license must meet continuing education requirements established by the board;

i) specify the statutory provision which exempts individuals performing acts described under the practice act provision or at the instruction of one licensed by the Texas State Board of Medical Examiners;

j) amend the statute to require that new graduates hold time-temporary permits be supervised by an R.N.;

k) provide statutory authority for the board to recognize and regulate areas of specialty practice within the scope of the practice of professional nursing;

l) amend the statute regulating the practice of professional nursing to prevent professions, trades, or occupations from using titles which otherwise would constitute the practice

SUSAN J. GROBE, R.N., Ph.D., is assistant professor at the University of Texas, Austin, School of Nursing. She completed the survey of state boards of nursing described here as part of her involvement in the Texas sunset review. Partial funding for the survey was provided by the Center for Research, University of Texas, Austin.

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out which principles are included in a state's sunset statute from various sources. The information ought to be available from the sunset commission of the state legislature, an individual's state legislator, the state nurses' professional association, and the state board of nurse examiners.

Questions in review. Though the criteria used for the review process are specified on a state-by-state basis, the most common questions asked of agencies under review usually refer to the agency's effectiveness, efficiency, scope of regulatory responsibility, response to complaints, and compliance with open meetings and open records acts. Areas of concern with health care provider boards also may include conflict of interest concerns related to board members' activities and issues focusing on advertising and restraint-of-trade practices. Board membership criteria and the feasibility of adding public members to a health regulatory board to represent the public interest are often discussed. Specific questions about the necessity for and the nature and effects of licensing health personnel can also be addressed.

When data is collected for an individual state's review and evaluation it is usually compared with data from other states. The sunset

the agency . . . and the problem or need which the agency was intended to address, the extent to which the objectives have been achieved. . . .

(3) an assessment of less restrictive or other alternative methods . . . which could adequately protect the public;

(4) the extent to which the advisory committee is needed and is used;

(5) the extent to which the jurisdiction of the agency and the programs administered by the agency overlap or duplicate those of other agencies and the extent to which the programs administered by the agency can be consolidated with the programs of other state agencies;

(6) whether the agency has recommended to the legislature statutory changes calculated to be of benefit to the public rather than to an occupation, business, or institution that the agency regulates;

(7) the promptness and effectiveness with which the agency disposes of complaints concerning persons affected by the agency;

(8) the extent to which the agency has encouraged participation by the public in making its rules and decisions . . . ;

(9) the extent to which the agency has complied with applicable requirements of an agency of the United States or of this state regarding equality of employment opportunity and the rights and privacy of individuals;

(10) the extent to which changes are necessary in the enabling statutes of the agency so that the agency can adequately comply with the criteria listed in this section;

(11) the extent to which the agency issues and enforces rules relating to potential conflict of interests of its employees;

(12) the extent to which the agency complies with the "Open Records Act" . . . and with the "Open Meetings Act" . . . ;

(13) the impact in terms of federal intervention or loss of federal funds if the agency is abolished.

Recommendations

Sec. 1.11. In its report on a state agency, the commission shall:

(1) make recommendations on the abolition, continuation, or reorganization of each affected state agency . . . ;

(2) recommend appropriation levels for each state agency and advisory committee for which abolition or reorganization is recommended . . . ;

(3) include drafts of legislation necessary to carry out the commission's recommendations . . .

of medicine. But who is recommended by the medical and medical profession as proper to perform the duty of professional nurse when performed in accordance with rules and regulations jointly prescribed by the Board of Nurse Examiners and the Board of Medical Examiners . . .

(d) permit professional nurses with advanced education and training certified by the Board of Nurse Examiners to possess, provide, dispense, or administer prescription medications, excepting controlled substances . . . jointly developed and promulgated by the Board of Nurse Examiners, the Board of Medical Examiners, and the Board of Pharmacy . . .

(e) require all parties to keep and maintain adequate medically justified records . . . ; and

(f) amend the statute to require that licensees clearly be identified as registered nurses . . . when providing services.

• **May 1980.** Public hearings were held by the eight member Sunset Advisory Commission, consisting of eight appointed Texas legislators, four senators and four representatives, with the evaluation staffs for the two houses. Committee members heard from consumers, individual nurses, and representatives from professional associations testifying for the Commission during these hearings. Subsequently, the Sunset Advisory Commission met and decided what recommendations to include in a bill submitted for creating the board and regulating nursing practice in Texas. Of the original 15 recommendations, only four—i, k, l, and m—were not included in the bill that was passed by the Sunset Advisory Commission.

• **February 1981.** [illegible]

validate the state's established norms and allows the state to benefit from others' experiences on related issues. For example, state boards of nursing vary widely in the type of practitioners regulated and the nature of board membership (see Profile of State Boards of Nursing shown on the right). As part of the sunset review, one state might look to the experience of another in deciding whether to delimit, expand, or maintain the composition of the board and the practitioners it regulates.

Strategies for Involvement

The bulk of the responsibility for responding to the evaluative criteria established for sunset review falls upon the state board of nurse examiners. However, two important times in the process, when both the individual nurse and the professional nurses' association activities become very important, are as follows.

First, once the sunset staff recommendations are made to a state's sunset commission, public testimony is invited. The sunset commission staff's recommendations become public record at this time. State professional associations are usually among those invited to offer testimony. Individual nurses served by the board may also be invited or may volunteer to offer testimony.

Second, once the state sunset commission has heard public testimony, it makes recommendations for statutory action to the state legislature. The entire legislature, through its committee structure, either reestablishes the board or makes recommended changes in the enabling statute (i.e., the Nurse Practice Act).

This second period is critical. Diligent and astute legislative monitoring and participation are essential to preserve the integrity of the nurse practice statute by either promoting or preventing changes.

Generally, the state's professional nurses' association, or those delegated to speak for the association, can speak for nursing at this time. However, additional political lobbying activities by individual nurses may be necessary.

It is important that all those

Profile of State Boards of Nursing[1]

State	Credential: RN only	Credential: RN and LPN/LVN only	Credential: RN and other	Number and Type Of Board Members: RN	LPN/LVN	MD	Public & Other	Total
Alabama		•		6	3			9
Alaska			•	5			2	7
Arizona		•		7			2	9
Arkansas		•		5	3		4[a]	12
California			•	5	2		2	9
Colorado		•		5	2		3	10
Connecticut			•	5	2		4	11
Delaware		•		5	2			7
Florida		•		5	2			7
Georgia		•		5	2		2	9
Guam			•	5	2			7
Hawaii			•	5	2			7
Idaho		•		5	2			7
Illinois		•		5	2			7
Indiana		•		5	2			7
Iowa		•		4	2		2	8
Kansas		•		5	2		4[a]	11
Kentucky		•		5	2		1	8
Louisiana		•		5	2		[illegible]	7
Maine		•		5	2		1	8
Maryland		•		5	2		1	8
Massachusetts		•		5	2		1	8
Michigan		•		5	2		1	8
Minnesota	•			5	2		1	8
Mississippi		•		5	2		1	8
Missouri		•		5	2		1	8
Montana		•		5	2		1	8
Nebraska		•		5	2		1	8
Nevada		•		4	2		1	7
New Hampshire		•		5	2		1	8
New Jersey		•		5	2		1	8
New Mexico		•		5	2		1	8
New York		•		5	2		4	11
North Carolina		•		5	2		4	11
North Dakota		•		5	2		1	8
Ohio		•		5	2		1	8
Oklahoma		•		5	2		1	8
Oregon		•		5	2		1	8
Puerto Rico		•		5	2		2	9
Puerto Rico		•		5	2		1	8
Rhode Island		•		5	2		1	8
South Carolina		•		5	2		1	8
South Dakota		•		5	2		1	8
Tennessee		•		5	2		2	9
Texas		•		5	2		1	8
Utah		•		5	2		1	8
Vermont		•		5	2		1	8
Virginia		•		5	2		1	8
Washington		•		5	2		1	8
West Virginia		•		5	2		1	8
Wisconsin		•		5	2		1	8
Wyoming		•		5	2		1	8
Washington, D.C.		•		5	2		1	8

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Profile of State Sunset Statutes[1]

State[10]	Sunset statute adopted	Sunset periodic termination clause[11]	Cycle of years for review[12]	Year of nursing board review[13]
Alabama	1976[14]	yes	4	1984
Alaska	1977	yes	4	1979
Arizona	1978	yes	6	1983
Arkansas	1977	no	1	1981
Colorado	1976	yes	6	1982
Connecticut	1978	yes	5	1983
Delaware	1980	yes	4	1984
Florida	1976	yes	6	1982
Georgia	1977	yes	6	1983
Hawaii	1977	yes	6	1983
Illinois	1978	yes	10	1988
Indiana	1978	yes	10	1988
Kansas	1978	yes	6	1984
Louisiana	1976	yes	4	1979
Maine	1977	yes	10	1987
Maryland	1978	yes	6	1984
Mississippi	1979	yes	8	1983
Montana	1977	yes	6	1983
Nebraska	1977	yes	6	1983[15]
Nevada	1979	no	0[16]	
New Hampshire	1977	yes	6	1983
New Mexico	1978	yes	6	1984
North Carolina	1977	no	2	1981
Oklahoma	1977	no	8	
Oregon	1977	yes	8	1985
Rhode Island	1977	yes	5	1982
South Carolina	1978	yes	5	1983
South Dakota	1977	no	0[17]	
Tennessee*	1977	yes	6	1983
Texas	1977	yes	12	1989
Utah	1977	yes	6	1983
Vermont	1978	yes	4	1982
Washington	1977	yes	4	1981
West Virginia	1978	no	2	
Wyoming	1978	yes	4	

Footnotes

Based on September 1980 survey.

*The board of nursing in 2 states (Tennessee and Texas) was created by a 1975 statute that provided for termination at the beginning of the following year unless reenacted by the legislature. Both boards were reenacted in 1977 and 1979, respectively.

[1]CMHC: Mental Health Centers Act (PL 94-63, 89 Stat. 308, 42 USC 2689 et seq.).

[2]Amendment (TA).

[3]An additional state has a sunset law applicable to boards, but the nursing board is not scheduled for review.

[4]Includes 3 boards (Funeral Directors, Tax Appeals, and [illegible]).

[5]Includes 2 MSITs.

[6]Ex officio.

[7]Includes two surgeons with podiatric practices.

[8]One RN must be the director of a state-approved school of nursing.

[9]Represents the whole Sunset Board (3 members and 2 staff).

[10]States without a sunset statute (Alaska, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming) have periodic review of state agencies but no sunset termination provision.

[11]Refers to sunset principle that all agencies will terminate unless reenacted by the legislature after review.

[12]Refers to how frequently the agency must be reviewed.

[13]Year specified by law nursing board review is to commence. Subsequent dates for board review are specified.

[14]Amended in 1979.

[15]Sunset statute expires in 1983, unless reenacted by law.

[16]Statute does not specify exact time when review will occur, but can be done anytime prior.

[17]Sunset statute enacted as a pilot project. Only those agencies specifically designated are reviewed.

Board of Nursing is not currently scheduled.

[18]Nursing board not scheduled for review at time of survey.

[19]Anticipated year, exact date not specified.

[20]Nursing board not one of the state agencies specified for review.

speaking at either of these times do so with a clearly unified voice. Dissension causes confusion in the minds of the sunset staff, sunset commission members, and other legislators who will be involved in reenactment of the nursing practice act.

Consensus signifies strength. Therefore, compromise and consensus should be worked out within the nursing community before nurses begin speaking out. After consensus has been achieved, a strong, unified voice should be presented.

There are several issues on which consensus can be reached readily. Most would agree that if censure is an effective mechanism for protecting the public from those unqualified to render nursing care. It is also in the public interest to maintain a board of nurse examiners to monitor nursing practice in the state and to use the national state board test pool system, which standardizes nursing licensure nationwide, to define minimal standards for entry into nursing practice.

There are several related issues on which consensus must also be reached.

- The current structure of regulation of nursing practice by nurses should be maintained.
- If public members are added to nursing boards, "public" must be defined clearly.
- Study and research are necessary before adopting any alternative approaches for regulating health professionals.

It is evident that there must be agreement on at least these basic issues in order to enable the sunset review process.

Although it is unlikely that the sunset audit will lead to deregulation of nursing practice, the nursing profession must be ready to assure public needs are being met and be ready to guard the existence of regulation of nursing practice and to maintain the strength of state nurse practice acts.

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INSTITUTIONAL LICENSURE... A PROFESSIONAL IDENTITY CRISIS

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Formal presentations and highlights of the ensuing interpanel discussion of the program "Institutional Licensure. . .A Professional Identity Crisis" sponsored by the Alumni Association of the State University of New York at Buffalo, School of Nursing. The program was conducted April 4, 1973 at Buffalo, New York.

The New York State Nurses Association gratefully acknowledges the efforts of the Alumni Association of SUNY at Buffalo, School of Nursing in arranging the program and their generous permission to share the proceedings with the nursing community through this publication.

Additionally, NYSNA wishes to acknowledge the efforts of the program's participants in preparing their presentations for publication.

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INSTITUTIONAL LICENSURE
A SNARE AND A DELUSION

Cathryne A. Welch, M.A., R.N.

Before I offer my prepared comments, I will take the opportunity to respond to two of Mr. Hershey's comments because I'm afraid they may get lost in the "institutional shuffle" a little later. First, with regard to the fact that the Association did not consult Mr. Hershey about the editorial "Hershey Bars and Other Unhealthy Confections"[2] — we didn't understand that we had a "reciprocal" relationship with Mr. Hershey since he has never consulted the Association about the nursing examples he cites as support for institutional licensure proposals. Secondly, with regard to whether the vested interests of the paid employees of the New York State Nurses Association involve conflict between the profession's interest and the public interest — let me assure you as your paid staff member (those of you who are members) that I know of no instance in which my obligations and commitments to the interests of nursing conflict with my obligations and commitments to the public interest.

In the judgment of The New York State Nurses Association, institutional licensure is a snare and a delusion. I choose these words deliberately and use them advisedly. "Snare," according to the Britannica World Language Dictionary, is a trap — something which gets people into trouble and entices them to do evil. A "delusion" is a false belief.[1] Institutional licensure is a proposal based on totally erroneous conceptions regarding

1. the nature of health care services and the various components of health care services, for example, medical practice and nursing practice; and
2. the legitimate and essential responsibilities and authority of individual practitioners vs. the legitimate and essential responsibilities of employing and regulatory agencies.

It is a proposal which, if implemented, would vest wholly inappropriate power over the definition and control of the practice of individual health workers in the hands of ill-prepared administrative personnel at local and governmental levels. Therefore, it is a proposal fraught with danger — for the public, for health care personnel and, ultimately, for health care institutions themselves. Permit me to elaborate.

I. Erroneous Conceptions Regarding the Nature of Health Care Services.

As the Association has previously noted, planning for the organization and delivery of health care services "is increasingly characterized by a spirit of anti-intellectualism and anti-educationism. While some believe this phenomenon is a fundamental characteristic of the American public, we believe its current pervasiveness in the health professions is a direct result of the involvement of 'Manpower Manipulators' and other strategists whose major area of expertise is a non-health discipline. These planners appear determined to reduce health care to its lowest common denominator, to seek ever smaller units and components of the entire health care package which may be delegated to some newly created group prepared specifically to 'handle' that particular unit."[3]

This conceptual approach to health care services is further complicated by the persistent and pervasive myth that "medical services" are synonymous with "health care services." This unfortunate view holds that all who practice in the health care arena are

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simply carrying out some aspect of a medical function and in essence, that all health care workers are either physicians or one of a growing variety of physician's assistants. (The effort to secure enactment of the revised legal definition of nursing practice in New York State provided ample evidence that lawyers and health care administrators are among the strongest proponents of this view.)

Again, as NYSNA has previously noted, "The frightening results of this process are more and more obvious. Consider the physician long respected for his mastery of complex bodies of knowledge and execution of critical judgments. He is now placed in the incredible and unenviable position of withdrawing from the practice of medicine to act as foreman in a developing health care factory."[3]

Consider Mr. Hershey's analogy between health services and football: "What a professional football coach would deem intolerable is part and parcel of our health care system. The coach of a professional football team must blend an enormous variety of skills and talents to create an effective team. He requires the freedom not only to select a roster of players who appear to have in the aggregate, all the skills necessary for team success, but also to move a player from one position to another based on the team's needs. Moreover, the mix of skills necessary for a particular position in professional football may change because of alterations in style of play and in the approach to the game. Changes in requirements demand changes in personnel. Without this flexibility, a professional team could not operate."[3]

...This unfortunate view holds that all who practice in the health care arena are simply carrying out some aspect of a medical function...

We believe that technological, assembly-line and football team concepts are totally incompatible with the very nature of health care services -- services which include not only discrete and unique medical components, but discrete and unique nursing components as well as others -- services which demand that individual practitioners possess and implement "carefully integrated blends of scientific and humanistic skills and competencies."[3]

II. The Legitimate and Essential Responsibilities and Authority of Individual Practitioners vs. the Legitimate and Essential Responsibilities of Employing and/or Regulatory Agencies.

If we accept the premise that professions offer unique and essential social services, (and it is clear that not everyone here *does* accept that premise) then it is obvious that the given profession itself must be held accountable for the continuing definition of its services, preparation of practitioners and provision of services to society. Professions must retain this accountability over time, over advances in science and technology and over changing demands and requirements of a society for preparation of practitioners and actual provision of services. The organizational context in which services are rendered ought to impose no restraint or constraint upon execution of fundamental professional obligations.

Administrators of health care agencies are responsible for facilitating the delivery of services, *not* for defining the nature of services to be rendered, nor the kind and degree of educational preparation basic to practice. Historically, one reason individual licensure laws came into being was recognition of the fact that administrators *ought not to be held accountable for the preparation and competence of health practitioners.* There is no question that administrators must be highly knowledgeable about health care services, about business and organizational management - but, clearly, they cannot and *ought* not

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to be expected to be as knowledgeable about scope of practice or about definitions and descriptions of practice as are members of the given professional group.

Mr. Hershey poses to those supporters of individual licensure a challenge to speak to the issue of "does licensure qualify?" There is no question that single, one shot individual licensure is a system fraught with problems. There is no question that some people licensed are incompetent at the time of licensure, remain incompetent throughout their practice or at some point may be discovered to be incompetent. But that is no excuse for throwing out a system designed to guarantee that as *many* people as possible seeking entry into the practice of a given profession will in fact be competent, given the inadequacies of testing procedures and the myriad complexities involved in measurement of individual competence particularly in the area of cognitive skills.

. . .It is obvious that the given profession itself must be held accountable for the continuing definition of its services, preparation of practitioners and provision of services to society. . .

As to the policing function, Mr. Hershey cites in his most recent comments, "one Pennsylvania nurse." I would challenge Mr. Hershey to give any evidence that a policing function administered by an individual agency would be more effective or more in the public interest. I cite as an example of the kind of policing function that would be authorized under institutional licensure the following group decision made by an attorney, an administrator and a physician of a large health services administration in this state (an agency which last year conceived and managed to have introduced into the legislature a bill embodying the concept of institutional licensure). That decision was:"...a nurse may make a nursing diagnosis that a particular patient ought not to receive a medication prescribed by a physician. In that instance, she shall contact the patient's counselor or the unit physician. If the physician determines in a medical diagnosis and medical judgment that the patient should indeed be medicated, the nurse who refuses to medicate the patient has the following alternatives: 1. medicate the patient under protest, in which case she will write out a medical rationale for her refusal or 2. continue in her refusal to medicate in which case the nurse will be terminated from her employment with this unit."[7] Obviously, this is "police" action; however, its quality and implications are debatable.

As to "career ladder" opportunities, I suggest to Mr. Hershey that the philosophy of that single group that he would allow to remain individually licensed-physicians, (even though Mr. Hershey himself doubts the realm of practice of the physician and obviously believes that most of that practice can be delegated to any number of groups) is a major impediment to career mobility and career ladder opportunities. Any emerging group must "take on" politically and professionally organized medicine, which views the emergence, enlargement or improvement of services by any other group as an "unwarranted attempt to infringe upon the practice of medicine." This is, in fact, an impediment to career mobility and I see it not being improved at all by a system of institutional licensure for all others excluding the independent entrepreneurial physician. I would submit then, that career opportunities can be improved by those of us who represent "vested professional interests" becoming more realistic about measuring competence for entry into practice, becoming more flexible, more imaginative, more innovative, more respectful of procedures other than those traditional. I further submit that health career opportunities could also be improved if other groups would cease to denigrate areas of practice other than medical practice and move accordingly.

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Dr. Simms has already shared with you some examples of the practical impact of institutional licensure. I would like to share a few more. What becomes of nursing care services under a system of institutional licensure? This is a critical question despite Mr. Hershey's suggestions that it doesn't matter what the service is called as long as it is done and, further, that it can be done by anyone, nurse, physician or any other group. This flies in the face of the concept that there is something which is uniquely nursing. If you believe there is such a thing as nursing (and I regret that Mr. Hershey does not believe that, because I think his view of this whole matter might be quite different) then you must also believe that we, as an organized professional group, have the responsibility for maintaining perpetuity of those services. We, (and perhaps we alone) recognize what nursing services are. We, and we alone, have the obligation to protect the survival of these services and to protect public access to those services. The possibility of that protection, in my judgment, is exceedingly slim under a system of institutional licensure for a number of reasons.

Not many years ago the American Medical Association announced that it would welcome into the ranks of physician's assistants thousands of nurses because they constituted a well-prepared pool of physician's assistants. There was no consideration on the part of organized medicine as to the impact on quantity, quality or availability of nursing care services if 50 to 75,000 nurses suddenly bolted the ranks of this profession. At a more local level, The Hospital Association of New York State at the time of the effort to secure the legal definition of nursing in New York State indicated that one of the reasons that Association could not support a definition of nursing, which would embody independence for nursing practitioners, was that hospital administration might find itself in an untenable position in the incident of medical-nursing conflict. Therefore, it appears that if organized medicine believes that the function of nurses and nursing is to serve as a physician's assistant, then hospital administration will sooner or later believe so also. I submit as further evidence, a February memorandum circulated by the Hospital Association of New York State in which it is stated that "hospitals as the major employer of nurses. . .have an interest equal to that of the nursing profession" in regulations governing nursing practice. The memorandum further suggests that the Association supports the view that in the instance in which a nurse is an employee of the hospital she is not in fact an independent practitioner but is in fact subject to the rules, regulations, authority, etc. of her employer.[6]

. . .A system of institutional licensure would only strengthen administrative efforts to exclude nurses and other groups from the exercise of necessary and legitimate responsibilities and prerogatives. . .

Finally, further evidence, I call your attention to the refusal of one of the largest health care systems in this state to discuss at the negotiating table the matter of position descriptions for nurses. The rationale for this refusal is that determination of responsibility and authority of employee positions is a "managerial prerogative" and, therefore, the employer is under no obligation to heed the views of the professional practitioner relative to legitimate scope of practice, appropriate responsibilities and qualifications. Naturally, the Association unequivocally rejects this interpretation and will continue its aggressive efforts to enable nursing practitioners to participate fully in the formulation of their own position descriptions. But the issue is clear — a system of institutional licensure would only strengthen administrative efforts to exclude nurses and other groups from the exercise of necessary and legitimate responsibilities and prerogatives.

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But you may be saying to yourselves "surely an accredited agency just can't run rampant, being as unlawful and irresponsible as some of these examples would suggest is possible." Under a system of institutional licensure where a governmental regulatory agency would establish the guidelines under which an individual agency would function, what could we *reasonably* expect? I need not comment on the repeated assertions by representatives of our governmental regulatory agencies, both the State Department of Health and/or the State Education Department of the lack of resources for carrying out their present functions. I need not comment on the delays in procedures currently being executed by governmental regulatory agencies. But permit me to cite one other dimension.

In a study published in 1970 by a group of physicians (Chiefs of Staff, as a matter of fact) we find some interesting comments. Under a heading entitled State Health Department

> "By *no stretch of the imagination do the vast majority of the municipal hospitals meet minimal standards.* Yet year after year the *State Health Department*, in a clear-cut *dereliction of its responsibilities*, closes its eyes to the conditions at the hospitals, which each year doom thousands of patients to poor care, extended hospitalization, suffering and even death unnecessarily. As one Health Department official indicated, the State Health Department policy is to deal rather severely with any infraction of the Code by a proprietary hospital, but to look aside from much more serious violations by municipal hospitals. It is not difficult to speculate on the reasons behind this attitude, for an honest exposure of conditions would demand correction, which would force the city to expend enormous sums of money, ultimately to have to be made up by the State. A 'gentleman's' agreement between City and State thus prevents embarrassment for each, at the expense of the voiceless sick poor. The State Health Department, an administrative arm of the State government, can ill afford to stimulate a costly upgrading of municipal hospital care whose *deficiencies* in recent years can in no small measure be *attributed* to the unconscionable *reductions in medicaid coverage by the State.*"

The authors make similar comments about the Joint Commission on Accreditation of Hospitals.[4]

. . . We, and we alone, have the obligation to protect the survival of these (nursing) services and to protect public access to those services. . .

And what do others think of institutional licensure, those who are non-nurses, who perhaps have a less vested interest? I quote from the *Health/PAC Bulletin* (The Health Policy Advisory Council has also been labeled by some as a suspect kind of group, but, nevertheless, they are another voice):

> "There is no reason to believe that institutional licensure would help workers or patients. Rather, it would simply take control away from the state governments and the professional associations and give it to the institutions. One administrator of a large Eastern voluntary hospital, when asked what changes he would advocate, shrugged and replied that tasks would be pushed down the line: 'Maybe LPN's would administer medications.' In other words, institutional licensure will enable hospital administrators to save money by transferring jobs from highly-paid personnel to workers with lower salaries. Cost cutting then, not innovative changes in service, is what is meant by 'rationalizing' the health labor force.

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Best of all, from the hospital administrator's point of view, the hospital would have an iron-clad grip on its workforce. Work discipline would be easier to enforce because workers would know that their economic security was totally dependent upon courting the favor of the hospital administrators. No longer could workers fall back on the security and sense of job mobility which membership in a profession association promises and to some degree delivers."[8]

Health/PAC comments further:

"The continuation of the status quo is no solution. There is a desperate need to lessen the fragmentation of workers and the loss of career mobility which the laws encourage. Credentials which increase economic security unfortunately also divide workers. Changes which might deal with these problems, such as elimination of formal, inflexible educational requirements and provisions that the employing institutions pay for continuing education, will not happen because they are not in the interests of the powers in the health care industry — the doctors and the institutions. The danger is that before pressure comes from workers for unification, changes will be made under the guise of improving efficiency which will increase institutional control, and further alienate workers from their jobs and from each other."[8]

...Institutional licensure, however well-intentioned, is at best a simplistic anti-intellectual proposal...

In sum, institutional licensure, however well-intentioned, is at best a simplistic anti-intellectual proposal. In the words of the legal counsel of the New York State Nurses Association, it is an example of attempting to "deal mathematically with non-mathematical issues." Its net effect would be to plunge health care back into the dark ages and to eventually require that whatever remained of existing professional groups readdress themselves to all the basic questions we now face. History suggests that at the point of collapse of the system of institutional licensure, some visionary prophet would emerge and propose a new system for increasing individual competence and accountability – in other words, individual licensure.

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Attachment #2

Hospital Association of New York State

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Albany

February 1, 1988

Ms. Lorna McBarnette
Executive Deputy Commissioner
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1495
Albany, New York 12237

Dear Ms. McBarnette:

On behalf of the Hospital Association of New York State (HANYS) and its members I wish to convey comments regarding the final draft report of the Labor-Industry Task Force on the shortage of health personnel. We believe that the report recognizes many of the problems faced by the health care provider today and details how we, along with government and other sectors, can work to solve current difficulties.

HANYS' testimony before the Task Force last summer enumerated specific causes of the shortage: stress, schedule, salaries, image, lack of respect, the AIDs crisis and changing roles for women. At various points in the report, all of these causes are examined. The crisis presents us with the opportunity to creatively utilize the resources we have and to seek solutions on many different levels, pertinent to organization of work, allocation of tasks, educational prerequisites and so on. HANYS will be supportive of subsequent efforts to implement solutions as long as these solutions do not in themselves create new problems in assuring access to and the delivery and quality of health services.

Solutions are suggested which address many of the problems and although HANYS supports many of the Department's task force proposals, some are not sufficiently emphasized, such as financial support for salary and benefit adjustments. HANYS does support the

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recommendations in regards to the career ladders for the health professions and the development of a core curriculum to allow greater mobility among the professions; the attempts to identify and provide financial support to individuals wishing to increase career opportunities through education; the partnership envisioned of the educational system and health facilities.

Since this report is a reflection of the DOH perspective and synthesis of the Task Force's comments it should be represented as a DOH report. We ask that you consider further incorporation of our views and comments into the draft document which will be released for public comment and hearings.

Because the report is too long to critique page by page, we have commented on the major issues which continue to cause concern for the health care provider community.

In general, the language used in the report and its overwhelming length make it difficult for HANYS to support the report. Additionally, the report is too negative about the image of the health care provider community and health professions, thus contributing to some of the problems we face in attracting personnel. Recommendations regarding education, career ladders and professions underplay the importance of professional development in assuring quality performance. There is not a sufficient partnership between the regulatory system and the health care provider community to seek solutions to the crisis and work on implementing them. In addition, the Legislature, which will invariably play a role in solving the personnel shortage, has yet to be included in discussions about this serious problem. Financial considerations are not sufficiently emphasized and the solutions which are suggested may not resolve the current crisis. These findings are enumerated in more detail below.

o Language and length are problematic:

There are many places throughout the report where HANYS believes that the language is either overly general or in some cases inflammatory. We do not see the need to over-dramatize problems or to use words which do not contribute to the consensus of the task force. HANYS is also concerned that some of the general language of the report could raise expectations of health care workers

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which either should not or cannot be met. These specific provisions have already been brought to your attention.

o Interplay of education, professional training, and quality is not portrayed in a sufficiently positive light:

The reasons for the shortage of health personnel are many, requiring a reassessment of even the most fundamental premises of how people enter the professions and how staff are utilized. Providers need maximum flexibility in the utilization of staff. However, the utilization of staff is bound by considerations of adequate educational and professional preparation to deliver quality care.

The basic tenor of the report toward this interplay is perhaps best summarized in the following passage on page 6: "creative and flexible use of workers is constrained by: traditional patterns of use, professional guild requirements, union requirements, state regulations, and fears of malpractice." This language implies that professional training is aimed at excluding people from entry to the profession rather than assuring quality of functioning. HANYS does not agree with this point of view.

o Professionalism is downplayed:

Although the task force was responsible for making an assessment of the standards and credentials for the professions, the report only reflects the conclusion that professional requirements pose arbitrary and artificial barriers to career mobility with little contribution to quality. HANYS does not subscribe to this although we do support the elimination of any standards or credentials which are unnecessary. We do not believe that the report should conclude that such barriers exist, only that a systematic assessment is still needed to identify what components of professional preparation are not needed and what components should be retained. Conclusions are premature and should be omitted from the report.

Personal accountability for decisions and actions is fundamental to any profession. Therefore, independent decision-making based on problem or situation assessment and solving must be an integral component of professional preparation and functioning. Professional

accountability is also the principle means and a critical juncture through which providers assure quality of care. HANYS believes that any changes in decision-making authority and the ability to make independent judgements must have a solid basis in educational preparation. Therefore, we believe that with proper changes in educational curriculum, RNs, LPNs, Occupational Therapy and Physical Therapy Assistants could have expanded responsibilities. We do not support the recommendation that aides (OT,PT,Nurse) should be given responsibilities for independent decision-making since we do not believe that dramatic change in training can be developed as envisioned.

o Need for a partnership in devising solutions should be highlighted:

HANYS previously has mentioned that there are few solutions to the shortage which can be accomplished by the health care provider community in isolation of the regulatory agencies and Legislature. We also believe that the financial recommendations need to be reconsidered in this light. HANYS believes that there is the opportunity for a partnership between the regulatory agencies such as the State Departments of Health and Education and the health care provider community to devise new strategies and plan for the future. An organized health care system will only thrive in conjunction with an organized regulatory system. This partnership is not fully realized in the report.

o Contribution of the regulatory system to the shortage is downplayed:

Earlier drafts of this report emphasized the need to carefully inventory all of the requirements which impose on or impede healthcare provider abilities to properly utilize staff. We see this as an essential component of any solution. HANYS also supports the consideration of impact on health care personnel for every new regulatory change. The mechanism by which such a systematic inventory of requirements can be accomplished is not contained in this report. HANYS would be glad to participate in such an enterprise.

The vehicle for uniting all the parties concerned with the shortage is not sufficient:

The recommended structures suggested for interagency cooperation and an advisory board consisting of health

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care provider community representatives separates the regulators from the advisors. HANYS suggests that a more appropriate arrangement should also include the Legislature and could be modeled after the Council on Health Care Financing. The partnership within such a council would assure that a positive framework exists within which constructive plans to deal with current and future needs could be made.

o A clear commitment to financial support for changes is lacking:

After all the discussions which have been held, there is insufficient emphasis within the report's Executive Summary of the need for financial support to deal with the many suggested increases in wages and benefits. One of the anticipated recommendations was the consideration of the fiscal impact of the recommendations and the potential consequences of implementing them. Although the Department of Health has added financial considerations to the report, a commitment to assess each of the recommendations with respect to financial impact is still missing. Also missing is a description of the sources of financial suport for each recommendation. As these recommendations are refined and implemented, these considerations will become an essential ingredient in the success or failure of these efforts. There is an ambivalence within the report in facing squarely the economic realities which underly the shortage problem.

o Need for comparable worth studies demands further analysis:

The report advocates the use of comparable worth studies as a first step in eliminating inequities of payment. HANYS cannot support use of comparable worth studies which only include individual facilities or a particular segment of the health care provider community.

There is no evidenced connection between the current supply problem we are facing and comparable worth. It is possible, for example, that such a study might indicate a lowering of salaries of nurses and raising that of aides. Such was the similar result of the comparable worth study performed by the state government. The result of a comparable worth study may be largely irrelevant to the financial solutions needed to resolve the shortage.

The report seeks to inappropriately place blame for the shortage on management failures:

The report qualifies financial support for increases in salaries to assurances that shortages are not due to poor management or inefficiency. Aside from the sheer impossibility of splicing out what is due to management and what is due to the realities of supply and demand, the real issue is the support needed to implement many of the suggestions of the report, and the realities of this shortage. The existence of shortages or needed remedies, which must include increased reimbursement for services and care, cannot be faulted to the health care provider community.

o Language of the report improperly characterizes the shortage:

The report is overly general about salaries/working conditions which contribute to the shortage.There are many general statements about wages and working conditions which may not be applicable to all areas of the state or to all facilities. One such statement appears on page 1, paragraph 4 which describes "poorly designed jobs that are inefficient, unrewarding, and fail to challenge." These statements imply that all jobs and health care occupations are unrewarding with deadends and poor pay. The fact is that many jobs may be very rewarding.

o Health care provider community image is not addressed:

The report fails to deal with the problems of the image of the health care provider community. It is, after all, not simply the image of the health professions which keeps people from pursuing health careers. It it also the image of the settings in which health care workers are employed that is problematic. HANYS has asked and continues to ask that the Department of Health squarely face the role that it plays in portraying the health care provider community in a negative light. There appears to be a total lack of sensitivity to the fact that in its regulatory efforts to assure quality of care, the Department of Health may be creating the very conditions which make providing quality of care difficult. Without commitment to changing this situation, the potential of this report will not be fully realized.

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In conclusion, although we support many of the report's recommendations, HANYS has many problems with the overall tone of the report, the problems identified and the proposed solutions. HANYS applauds the decision to widely circulate this draft report and to hold public hearings on the findings and recommendations. A broad consensus will be needed to achieve the many solutions envisioned. The next step should be to identify those tasks which can be done in the short term and those which must await a broader consensus or more study. The report certainly brings all concerned closer to understanding the many problems which face us and points to some of the directions needed to solve them. HANYS looks forward to resolving this crisis through realistic and responsible solutions which are within our mutual reach.

Sincerely,

Dan Sisto

Daniel Sisto
President

enclosure

Hospital Association of New York State

After review of the draft report of the Labor-Health Industry Task Force on Health Personnel, HANYS recommends that the following statements be deleted from the report. Due to its length, we could not identify for you all the questionable content.

Page #	Section	Comments
1	Fourth paragraph; poorly designed jobs	Too negative
5	Item 4; delivering health services	Speculative
6	Item 6; use of workers Item 9; Bell Committee	See our letter We disagree that this is the conclusion
7	Recommendations	Extensive revision needed
8	Second to last paragraph; RNS to prescribe meds	Delete
9	Item 2, first sentence; State Health Service Corps	Will only help with state facilities/ agencies
15-24	Industry image	Not dealt with, sources are lacking
31	Paragraph 5, last sentence; Right to die, reduction in demand	Disagree
32	Last 3 paragraphs; reimbursement	Page 35 refutes this. Page 36 denies it as far back as the '70s
33	Last paragraph; Patients may object	Of course patients will object
36	Paragraph 4; CON description	Disagree
38	Paragraph 2, last sentence; If HMOs are ...	Speculative
39	Paragraph 3, first 2 sentences; chains, networks, diversification	Not realistic for HHS
43	Last sentence; While patient ...	Will not decrease the demand for health workers

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Page #	Section	Comments
49	Second to last paragraph; last sentence	Disagree with using military as a model
53	Second paragraph; first sentence; barred experimentation	Unclear
	Sixth paragraph; BS for RN	Delete
55	Third paragraph; entrance exams - SAT, ACT	Disagree
57	Top paragraph; new reimbursement methods	Has the inception of DRGs actually led to decreased educational involvement, early discharge, etc.?
57	First paragraph under Working Conditions; last sentence	Delete
57/58	Last paragraph on 57 and first 3 on 58; quote from the nurse	Delete
58	Paragraph 5; last sentence	More independence for a RN in a Drs. office vs. acute care is questionnable
62	Paragraph 3; jobs pay about $4,000 less	Contradicts page 61, paragraph 3, scarcity of data
72	Second from bottom paragraph; marketing to males	Doubtful
103	First paragraph; number of vacancies, first 2 sentences	Delete
109	#3; If the number of nursing home ...	Delete
114	Pharmacy	Section ignores hospital vs. drug store disparities. Data was supplied by HANYS
127-137	Recommendations	Revise per prior comments and letter

Health Bulletin #88

Senator Tarky Lombardi, Jr., Chairman
New York State Senate Health Committee

TASK FORCE ON RECRUITMENT, TRAINING & RETENTION OF HOME CARE WORKERS -- A PROGRESS REPORT

Room 612, Legislative Office Building
Albany, New York 12247

RECRUITMENT, TRAINING & RETENTION OF HOME CARE WORKERS: A SERIOUS PROBLEM

THE PROBLEM

The shortage of qualified home care workers, particularly home health aides and personal care workers, has emerged as perhaps the most serious issue affecting the delivery of home care services. Problems with recruitment, training and retention of these essential personnel are reported statewide, across all types and sponsors of home care programs, are said to have reached crisis proportions in some areas, and appear to result from multiple factors. The depth and complexity of the problem necessitates a broad range of short and long term actions at all levels.

The home health delivery system has evolved from a relatively small component of the health delivery system to an essential link in the continuum of care. This is largely the result of policy changes affecting the use of institutional care, the increasing costs of health care, the increasing demand for long term care, and the overall preference by patients and families for care at home.

A tremendous dependence on home care has emerged, with expectations that home care will fill gaps in the health delivery system, meet the increasing needs for post-acute and long term care, and provide care that is patient-oriented and cost-effective. The high expectations and significance placed on home care have been well earned through a proven record of high quality, efficient care.

If the home care delivery system is to fulfill its challenging mandate, there must be an adequate supply of qualified, competent personnel to deliver the care. The home care aide is at the core of the home health delivery system -- generally comprising most of the formal caregiver time spent with the patients, assisting patients with their daily personal care and household needs and providing emotional and social support. The quality and ultimately the viability of home care often rests with the aides; there would be little home care without them. Thus, the implications of the worker shortage are serious not only for home care, but for the entire health care delivery system which has come to depend so heavily on community care. Ultimately, the area of greatest concern must be the impact on those in need of care.

SENATE HEALTH COMMITTEE SYMPOSIUM ON RECRUITMENT, TRAINING & RETENTION

In response to growing concerns over the difficulties in recruiting and retaining home care workers, and in order to gain the widest base of information and the most productive suggestions, Senator Lombardi convened a symposium in Albany on February 4, 1987 to develop a better assessment of the needs and potential steps for corrective action.

Participants in the Symposium included representatives of the Legislature, State regulatory agencies, home care industry, labor and others closest to the problem. Although we expected about 50 persons, approximately 150 participated, reflecting the seriousness and scope of the issue. There was an open exchange of information and ideas and a great deal of information was shared.

Some of the comments and recommendations made at the February Symposium are summarized below.

Scope of the Problem

- The problem was reported to exist statewide, across all types of home care providers and programs.
- It was reported that there is a 50% turnover of employees in New York City's Home Attendant Program.
- Providers have been forced to cancel training sessions due to a lack of recruits.
- One agency stated that despite providing benefits, uniforms, vacations, retirement, health insurance, etc., there are still problems with recruitment and retention.

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Contributing Factors/Issues for Attention

- Health system and demographic changes resulting in increased need for home care.
- Low wages, limited benefits, lack of guaranteed income.
- Working conditions, including: isolation of the aides from supervision and peer support; poor condition of some homes and neighborhoods; weekend/evening work; irregular hours; no guaranteed work hours; lack of recognition and input.
- Lack of job mobility/career opportunities.
- Market conditions, including: relatively low unemployment; fierce competition by other parts of the job market offering better pay and benefits, less stressful working conditions, better job stability and career opportunities; decreasing number of new entrants into the labor pool.
- State and Federal regulations/requirements, including: conflicting regulations relative to training, education and work tasks, which limit flexibility in worker employment and assignment; Medicare and Medicaid reimbursement rates are at a low level, and Medicare fosters short, irregular hours; Medicaid reimbursement is not commensurate with State Labor requirements for worker pay.
- Personal factors, including: child care, income, and transportation needs. A profile of New York City aide characteristics (based on a 1985-86 survey conducted by Hunter College School of Social Work) reveals:
  - Nearly all home care workers (99%) are female; average age is 47.
  - Approximately 64% are single (unmarried, divorced, widowed).
  - 64% lack a high school diploma.
  - 70% are black; 26% are hispanic; 46% are foreign-born.
  - 85% have children. The average number of children is 3.5.
  - Only 15% of the workers live alone; 65% live with children; 32% live with a spouse; the average household contains 3.5 persons.
  - 90% of the workers earn an annual salary less than $11,000; 76% are primary breadwinners; the median family income is less than $8,000/year.
  - 32% of the workers have no health insurance or benefits; 68% are minimally covered; 3% are covered by Medicaid.

Although this data is based on New York City only, studies of workers in other major cities show striking similarity in aide characteristics, except for relatively lower percentages of aides who are black or hispanic.

Impact on the Health Delivery System

- The aide shortage is reported to have a significant, adverse impact on the home care delivery system and the health care delivery system overall. Ultimately, the greatest impact is on patients and families seeking the needed care and support.
- Areas reported to be negatively affected are: quality of care, quantity of service, accessibility of care, numbers of patients able to be served, costs, and timely admission of patients into home care.

Recommendations for Action

- Improve wages and benefits.
- Establish a career ladder.
- Improve supervision, support and inservice education for aides, and provide training in special care areas, which could lead to increased job satisfaction and hence increased recruitment and retention.
- Provide resources to assist with aide training and certification.
- Standardize qualifications, job description, titles, training programs and certification.

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- Establish better guidelines for determination of hours authorized per case and for more effective and efficient management and assignment of aides generally.

- Increase job promotion and explore new labor pools.

- Conduct studies to assess the problems and needs, and develop a data base to help identify causes and potential corrective actions.

TASK FORCE ON RECRUITMENT, TRAINING AND RETENTION OF HOME CARE WORKERS

Despite the lack of quantitative or detailed data on the shortage, the Symposium nevertheless provided a great base of information with which to proceed. Immediately following the Symposium, Senator Lombardi, in recognition of the need for prompt action, convened a special Task Force on Recruitment, Training and Retention of Home Care Workers. The primary objectives of the Task Force have been to a) analyze the comments and recommendations made at the Symposium, and research additional information or areas relevant to the problem, and b) identify steps that could be taken to alleviate the shortage. Because of the urgency of the problem, the Task Force has primarily focused on immediate or short term actions for relief; long term actions are being explored as well.

The Task Force is comprised of representatives of the Senate and Assembly, State Departments of Labor, Health, Social Services, Education and Aging, State Council on Home Care Services, Home Care Association of New York State, New York Association of Homes and Services for the Aging, New York State Association of Health Care Providers, Hospital Association of New York State, New York Association of County Health Officials, home care providers and labor organizations.

The Task Force, at several meetings, has explored numerous issues and recommendations for action. Due to the complexity of these issues and the absence of data, concrete solutions to the broad problems have been extremely difficult to formulate. Progress has been made in a variety of areas, described below.

Training Grants

Recommendations were made at the Symposium and Task Force meetings that financial assistance be provided for aide recruitment and training. Of particular concern was the lack of payment to the aide during the training period and its negative effect on recruitment.

To provide some immediate assistance with this problem, Senator Lombardi was successful in gaining an appropriation of $2M in the 1987-88 State Budget for State grants for aide training and certification. Under this program, funds may be used for recruitment, instruction and subsidization of home health aide and personal care trainees. Implementation is underway and over 142 letters requesting more than $9.2M in funding were submitted to the State Department of Health by interested agencies and organizations. Sixty-six applicants were asked to submit full proposals by November 30 and grant awards are expected to be announced by December 29 for the contract period of February 1 - July 31, 1988.

Demonstrations/Innovative Projects

At the Task Force meetings, recommendations were heard to fund demonstrations or innovative projects in recruitment, training and retention to learn their impacts and to potentially serve as the basis for broader programs and changes. Although grant awards had already been determined for 1987-88, it was felt that the State's Home Health Grant Program might be a viable means of approaching this.

The Home Health Grant Program, expanded by Senator Lombardi in 1985 and approved by the Legislature for full funding again in 1987, made $2.738M in funds available to assist certified home health agencies to meet their communities' rapidly growing home care needs. The Department of Health reports that awards for 58 projects proposed by 42 sponsors have been approved for a contract period of 7/1/87 through 6/30/88. Three of the approved projects have been awarded funding for aide training: 1) Broome County Health Department; 2) VNA of Utica; and 3) Good Samaritan Hospital (Rockland County). Another project, sponsored by the VNS of Rochester and Monroe County, has been funded to investigate the economic feasibility of providing aides with transportation to clients living in areas difficult to reach by public transportation.

Job Promotion

To stimulate recruitment, the Task Force recommended that job promotion activities be increased immediately at the State and local levels.

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As a result, the State Department of Labor is developing, with assistance from home care providers, an occupational guide on home health aides which is expected to be completed in the very near future. This new guide will fit into a series of occupational briefs for 200 occupations. It is intended to describe and provide information on the home health aide occupation and will be especially targeted to younger persons.

During the Summer months, State Labor representatives met with local job service officials across the State to discuss the home care worker shortage and the need to work with home care agencies in the recruitment of potential workers. Also, State Labor representatives distributed to the various State Associations representing home care providers lists of local job service contacts for distribution to their members.

The State Education Department has initiated a number of projects to promote interest in the health care field: a 6-8 page booklet which will include a description of the need for new employees in the critical areas of health care; articles in Benchmark (a major Education Department publication printed five times a year with a distribution of 37,000) addressing the need to encourage students to enter educational programs in health careers; and a flyer promoting health careers for distribution to guidance offices for grades 6,7,8 and for general public availability in other settings such as doctor and dentist offices.

Revision and Coordination of State Regulations

One of the most often cited problems at the Symposium and the Task Force meetings has been the lack of common State standards and requirements pertaining to home care aides and the impact on recruitment and assignment of workers. It was recommended that, to the extent possible, State administrative and regulatory criteria with respect to training and certification, task assignment and other areas, be standardized and coordinated to promote flexibility and effective, efficient assignment of the aides.

Representatives of the various State agencies participating on the Task Force have been working cooperatively to develop administrative and regulatory solutions. Legislative action to promote resolution could be examined pending the outcome of these administrative activities, described below.

Standardized Assessment Methodology The Standardized Assessment Methodology (SAM) will allow home care agencies to conduct equivalency/competency testing of aides who have training and/or experience but have not completed State approved training programs leading to certification. This methodology has been field tested and is expected to be formally issued in conjunction with the Home Care Core Curriculum in 1988.

Home Care Core Curriculum The Home Care Core Curriculum, initially developed by SUNY Albany and revised by SUC Buffalo, is a curriculum for basic training of home care workers. It is now used on a voluntary basis with plans to mandate its use in 1988 for personal care workers. The State Department of Health is planning to incorporate the curriculum as part of home health aide training, and the State Offices of Mental Health and Mental Retardation/Developmental Disabilities are planning to use this curriculum as well.

Approval of Home Health Aide Training For Personal Care The State Department of Social Services has prepared an administrative directive which will allow persons trained as home health aides, according to State Health Department approved criteria, to be considered to have completed the necessary requirements to also serve as personal care workers. The directive, which is expected to be finalized and released by the end of the year, should address a major obstacle to flexible employment and assignment of home health aides.

Home Care Task Matrix The State Department of Social Services, in conjunction with the State Departments of Health and Education, has developed the Home Care Task Matrix, which for the first time will define the specific tasks personal care workers can perform, depending on their level of training (levels I, II, and III) and the patient's condition and needs. The Matrix will allow personal care workers (level III) and home health aides to perform the same functions and activities. The provider and professional communities are concerned about the appropriateness of certain health related tasks the Matrix indicates aides could perform. State agency representatives and a representative from the State Nursing Board have been meeting regularly to resolve these issues and finalize the Matrix, which is expected by the end of the year.

Combined Home Health Aide/Nurse Aide Curriculum The State Education Department is developing a curriculum which will allow students to complete one program of study leading to dual certification as a home health aide and a nurse aide. This should promote greater flexibility in recruitment for both home care

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agencies and residential health care facilities. This new curriculum is expected to be completed by August 1988 and available for use in school year 1988-89 by high schools, BOCES and proprietary schools for adult training.

Working Conditions/Management Practices

Difficult working conditions, along with the need for more effective management practices, are felt to be a major contributor to the recruitment and retention problem. While certain working conditions are inherent to the occupation -- e.g., difficult patients/families, substandard housing and dangerous neighborhoods -- the Task Force nevertheless felt that other elements could be influenced and recommended that actions be implemented on both a State and local level to improve working conditions and agency management practices.

An initiative recommended by the Task Force is a training conference, primarily for agency professional staff, on management practices to improve utilization and job satisfaction of aides. The State Council on Home Care Services, which is also seeking to address the problems in recruitment and retention, is planning such a conference, with input from the Task Force and others. It is scheduled for February 25, 1988 at the Empire State Plaza Convention Center. The proposed agenda includes workshops on such topics as marketing strategies, wages/salary and benefits, innovative training techniques, career ladder, and job and family stress. Management and workers alike are invited to attend. The fullest possible attendance is encouraged.

Immigration Laws

The Immigration Reform and Control Act of 1986 was signed by President Reagan on November 6, 1986. According to the Bureau of National Affairs (1987), "The new law attempts to control illegal immigration through a system of sanctions imposed on employers and other entities that refer, recruit or hire undocumented aliens." In view of the significant number of foreign-born persons in the existing and potential home health aide work force, it is possible that this new law may greatly exacerbate the recruitment and retention problem.

The Task Force recommended that careful study be given to better assess the new law's potential implications for aide recruitment and retention. A special subcommittee of the Task Force has been convened and is exploring this important issue.

Studies

As previously noted, a major obstacle to developing corrective strategies on the worker shortage is the lack of quantitative and detailed information. Further study of the problem was urged at the Symposium and recommended by the Task Force. A number of studies are now underway.

Home Care Agency Survey The State Health Department, in conjuction with other State Agencies, is conducting a survey of home care agencies to obtain information on recruitment, training and employment practices of home care agencies. This survey has been sent to 1100-1200 agencies involved in the provision of home care services. The current due date for returning surveys is December 15; to obtain the best possible data base, replies from all agencies are urged. A report based on this survey is expected to be completed by mid-1988.

Labor Market Analysis and Home Care Worker Studies The Legislature approved an appropriation of $150,000 in the 1987-88 State Budget for a study of the home health care and personal care industry to analyze the employment conditions of workers and issues affecting aide recruitment, compensation and retention. The Department of Social Services was successful in obtaining Federal matching funds for this analysis, which is being conducted as a two-part study by that Department in conjunction with other State agencies.

A contractor, ICF, Inc., has been selected to conduct a labor market analysis which will provide information on a) the supply of and demand for home care workers, and b) future data needed by the State to develop effective strategies to address recruitment and retention. This study is expected to begin within the next several weeks, with an interim report to be issued in Spring 1988 and a final report expected December 1988.

The home care worker study will involve interviewing 1500-1800 current and former home care workers to learn their perceptions of the occupation and their needs. A Request for Proposals to obtain a contractor for the study is being developed by the State Social Services Department and will be issued within the next several weeks. This study is expected to begin in Spring 1988, with issuance of the report expected by December 1988.

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FUTURE DIRECTIONS

Many efforts are underway to address the problems with recruitment, training and retention. There is currently wide recognition and action at all levels. Much remains to be done to alleviate this serious problem and to accomplish the changes necessary to assure the adequacy of our home health resources.

To this end, additional areas being examined for recommended action by the Task Force include:

Salary and Benefits

Salary and benefits is surely one of the most critical factors in recruitment and retention. Consideration of salary and benefits must be part of the overall plan of action if the problems are to be effec.ively resolved and long term needs fulfilled. A primary issue remains one of affordability -- affordability for the aide, the patient, the agency and the State -- and the continued efficiency of home care.

Working Conditions

Practices should be implemented to improve working conditions of the aides. Suggested areas for study and potential action include: peer supports, supervision, input into agency policy/procedure, inservice education, better matches between aides and patients, aide recognition, and others. A related employment issue, the potential effects of the recent revisions in the Federal Immigration Law, must be studied and considered as well.

Career Opportunities

Activities to promote entry into this occupation and to incorporate career opportunities are essential if quality personnel are to be attracted and retained. Some of the specific areas being examined include: allowing aides to specialize in particular areas; providing educational opportunities (e.g. the opportunity to obtain a high school diploma), and creating a path to other health occupations.

Reimbursement

Clearly, home care reimbursement plays a vital role in the wages and benefits agencies can offer and therefore bears careful examination. Agencies must receive adequate reimbursement in order to remain competitive for this worker population.

Regulations

Much is already underway to coordinate and standardize the administrative and regulatory requirements for aide training, certification and assignment. Numerous activities have been described in this Bulletin, the outcome of which are anxiously awaited. Further study and attention will be given to this area.

Still to be explored is the conflict between State Labor and Medicaid regulations with respect to payment. State Department of Labor regulations require that workers be paid for certain hours and circumstances for which Medicaid will not reimburse, further complicating a critical problem.

Effective Management

More efficient assignment of home care workers could enable the resources to be better distributed and thus help reduce the impact of the shortage. Recommendations/ requirements to promote more effective management should be explored.

Innovative Service Delivery Mechanisms

Innovative methods to more effectively and efficiently provide aide services or reduce reliance on aides must be explored. In addition, methods of assisting aides with personal factors -- such as transportation and child care needs -- which act as barriers to home health aide employment also require consideration.

The Task Force continues to study and recommend positive action on recruitment, training and retention of home care workers in order to allow providers to service those patients who need and expect to be cared for at home. Action at all levels is key to effectively resolving the recruitment and retention problems. We welcome your input and suggestions.

For further information on the Task Force, or to offer your comments, please feel free to contact our Albany Office at (518) 455-3511.

December 1, 1987

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NOTICE OF PUBLIC HEARING

REPORT OF THE LABOR-HEALTH INDUSTRY TASK FORCE ON HEALTH PERSONNEL

BACKGROUND: Severe shortages of personnel in selected health occupations threaten the availability and quality of health care across New York State. In response to this growing crisis, the Commissioner of the New York State Department of Health, Dr. David Axelrod, established the Labor-Health Industry Task Force on Health Personnel.

The task force found that both the causes and solutions to these shortages are multifaceted. Growth of the health care sector, aging of the population, declines in the number of young people available to enter the health field, and changing career options for women, combined with a heavy reliance on highly educated, credentialled occupations, are likely to exacerbate shortages.

Recommendations made by the task force are comprehensive and are divided into five broad areas: improvements in compensation and working conditions; fostering and supporting career mobility and career ladders; making more effective use of the existing workforce; encouraging new entrants into the health care industry; and establishing a more effective process for assessing future health personnel needs.

PURPOSE: The New York State Department of Health is holding public hearings to seek comments on both the specific content of the report and on the shortage of personnel across the state. Representatives from several state agencies will join the Health Department at the hearings. The department is seeking comments on :

1. The findings of the task force;

2. The recommendations made in the report; and

3. Possible additional or alternative recommendations.

Other Issues

1. Do existing state regulations or health facility practices contribute to or impede the effective use of the existing workforce? Specifically which regulations or practices are of concern?

2. Are there enough educational programs in health occupations, and are they accessible in terms of cost, location and time offered?

3. Do educational curricula in health occupations adequately prepare practitioners for current practice?

4. Are there existing or potential new labor saving technologies which could help improve working conditions and assist the current workforce?

TIME AND LOCATION: Public hearings will be held at the times and locations listed below. Testimony will be limited to approximately ten minutes, and those wishing to testify will be asked to provide a written copy of their comments at the time of the meeting. Please register to testify by filling out the attached form and sending it at least one week prior to the meeting you wish to attend. For further information, contact:

Vida Behn, Bureau of Health Resources Development, New York State Department of Health, (518) 473-3513.

Persons who have not preregistered may be permitted to testify if time allows. Written statements, in lieu of oral testimony, will be given equal weight and should be submitted to the above address by May 6, 1988. To the extent possible, those preregistering will be notified of the schedule of speakers.

SCHEDULE OF PUBLIC HEARINGS

Long Island: Wednesday, April 20 , 10 am to 4 pm.
Suffolk County Academy of Medicine
Auditorium, 840 Veterans Memorial Highway,
Hauppauge, NY

New York City: Friday, April 22, 10:30 am to 3:30 pm.
Lenox Hill Hospital Auditorium,
76th Street and Lexington entrance.

Syracuse: Thursday, April 28, 10:30 am to 3:30 pm.
Senator Hughes State Office Building
Main Hearing Room, First Floor
333 East Washington Street.

Albany: Tuesday, May 3, 10 am to 4 pm.
Chancellors Hall, State Education Department Building
Corner of Washington and Hawk.

Buffalo: Friday, May 6, 10:30 am to 3:30 pm
Buffalo and Erie County Public Library
Auditorium, Lafayette Square.
Note: entrance to auditorium is on Clinton St., at the corner of Clinton and Ellicott.

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REGISTRATION FORM

Name_____

Title_____

Organization represented_____

_____

Address_____

_____

_____

Phone number__(_____)_____

Date and location of the hearing you wish to attend:

_____

Return to: Vida Behn
Bureau of Health Resources Development
NYS Department of Health
1603 Corning Tower
Empire State Plaza
Albany, NY 12237

at least one week prior to the hearing date.

#85 HEALTH INDUSTRY LABOR REPORTS

MLO-2

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January 28, 1988

Ms. Lorna McBarnette
Executive Deputy Commissioner
New York State Department of Health
Corning Tower
Albany, NY 12237

Dear Ms. McBarnette:

The health care needs of the citizens of New York State require a strong commitment from the state in the areas of education, reimbursement and marketing. No one in this state will be adequately served by a piecemeal down substitution of isolated health care tasks. The New York State Nurses Association restates its belief that the problems related to recruitment and retention in the nursing profession are multi-faceted problem and require long-range and short-term strategies.

NYSNA's suggestions for addressing this problem continue to be:

1. standardization of nursing education for LPNs (associate degrees) and RNs (baccalaureate degrees) which would provide opportunity for legitimate articulation and promote career mobility;

2. a commitment by the state to establishing scholarships for nursing students and making monies available to universities and colleges for innovative programs;

3. a policy which would allow hospitals to close beds to elective admissions according to specific criteria, when there is inadequate nursing personnel to provide care, without jeopardizing the institution's reimbursement framework;

4. the development of criteria for certificate of need approval of additional bed allocations for facilities which include the availability of nursing personnel, current nursing staffing patterns/shortages and provisions for support personnel for non-nursing functions;

5. a direct incorporation of patient acuity/nursing intensity into the state's reimbursement methodology which should provide the incentive and resources for a facility to improve nurses' salaries and benefits;

6. appropriate financial compensation for nurses throughout their careers;

7. a portable pension system for nurses in New York State which could assist in stemming the out-migration of professional nurses;

8. an active and aggressive health careers recruitment program within the state;

9. prescriptive privileges for appropriately prepared nurses; and

10. direct reimbursement for nursing services.

To the extent that these items are recognized within the Labor Health Industry Task Force Report, NYSNA will be supportive of their implementation. However, this Association regrets the continued emphasis on strategies which call for periodic review of practice acts ("sunsetting") and programs outside of the regulatory and statutory requirements ("institutional licensure"). Sunset laws in other states have created bureaucratic nightmares. Institutional licensure would establish a practice environment in which both patient safety and quality of care will be compromised. In addition, the continued emphasis on additive educational patterns under the guise of career/educational ladders denies the educational differences inherent in the frameworks of the various nursing programs within the state.

These beliefs are echoed in the comments on the nursing shortage by a nursing leader from Connecticut, Judith Kraus, Dean of the Yale School of Nursing, to the Governor of her State:

> .... the solutions fall into five major categories: economics; the nature of the care environments in which nurses work; education; control of the profession; and image. We must all recognize that there is no one solution to the .... shortage and that the problems ... have been decades in the making and are likely to require long-term solutions. Where short-term solutions are necessary, we had best be careful that they do not establish a lower standard of care in the name of expediency, which will haunt us in the decades to come.

NYSNA draws your attention to the fact that the Report in its current format, has little or no documentation of its statistics, facts or basic premises. The final report must include appropriate footnoting and a complete reference list.

In addition, the report is replete with generalizations, beliefs and opinions which are based on inadequate data and the authors' own personal conceptions. It is often contradictory and misleading in its presentation of material.

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The final report should include a glossary of terms, to include, at least: medical services, health services, medical care, health care, vocation, occupation, profession, paraprofessional, entry-level, mid-level, and high-level. Also, the editor must assure that all terms are consistently used throughout the Report.

ANALYSIS OF DRAFT REPORT

Executive Summary

Remove all gratuitous language throughout the Report, e.g., "with the turf protection this implies;" "guilds;" "arbitrary;" "mired;" "bemoan;" "mother's hours;" and "women's work."

Page 2

The LPN vacancy rates cannot be categorized as "significant." Also, this rate is contradicted later in the Report.

Page 3

Physicians should control access to medical services; it is their "gate-keeping" to health services (nursing, the therapies, treatments) which is objectionable.

Page 5

As discussed at the recent meeting, NYSNA urges that attempts to correlate the fear of AIDS to career choices in the health professions be eliminated. Otherwise, this will be a self-fulfilling prophecy. It would be acceptable for there to be a balanced discussion of the Task Force's concern that increased public awareness of HIV, TB and Hepatitis B may have a negative recruitment impact.

Page 6

Item number 10 characterizes educational requirements and credentials as career mobility barriers. The overwhelming barrier is the lack of a high school education, not the profession's requirements.

Page 8

This page includes a discussion regarding expanding the practice of mid-level practitioners. NYSNA regrets the current activities by the Health Department in the area of the practice of licensed practical nurses and the administration of intravenous therapy, which seem to reflect the ideas proposed on this page regarding "constraints." These regulations were adopted over the expressed objections of the State Board for Nursing. There was a complete rejection of any compromise regulation by the Department of Health. The current pharmacology component of most LPN programs is less than 10 hours. NYSNA must

seriously question how this type of activity will be of benefit to the health of the citizens of the state.

Page 9

In IV-1, there is a bridging of high schools with colleges which would add a year to high school. Why not complete each educational program and receive the appropriate recognition? The additional year of high school should be the first year of community college or university.

I. Introduction

No specific suggestions.

II. Demographics

Page 19

NYSNA requests that the last paragraph's discussion regarding RNs, which is focused on eight year old census data, be placed into a proper statistical perspective.

Page 23

NYSNA strongly recommends removal of this unsubstantiated correlation between HIV/AIDS and the nursing shortage.

III. Demand

Page 27

The major section is labelled "The Need for Medical Services" when it should be identified as "The Need for Health Services."

Page 40

The Report should include the information which has been supplied to Department of Health staff regarding the significant shortfalls in baccalaureate and masters prepared nurses in the year 2000. Ignoring these data will not make the need go away!

Page 41

Add "nurse" before "midwife."

IV. Supply

Page 45

The entire section on "Licensure and Credentialing" needs to be re-done. Do not confuse licensure with certification; be clear and concise. It is inappropriate to confer licensure power on the Department of Health within a Task Force's Report.

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Page 47

In the last paragraph, how does sentence one relate to sentences two and three? NYSNA would agree that there needs to be a change in the educational requirements which will ultimately provide LPNs with associate degrees and RNs with baccalaureate degrees.

Page 49

In paragraph 5, NYSNA must challenge the Report's blanket statement that licensure is a barrier to more rational and effective use of health personnel. Also, while some studies may show positive results for the military model, the quality assurance studies of this same model seriously question the standards of patient care. One receives the impression from this Report that health care can be divided into "little tasks" which can be taught to providers with "minimal education" and because there are more individuals in the system, one need not fear for the quality of care which is being delivered. This is erroneous and dangerous.

Page 50

The comment that, in California, the experience with medical corpsman qualifying for equivalency assessment for RN licensure is incorrect in its presentation. This program which dates from 1975 is under serious re-consideration. There is only a 40 percent passing rate on the licensure examination and both the Navy and Air Force have informed the California Board for Registered Nurses that the current education of corpsmen does not prepare them for this type of equivalency assessment. Both military branches stress their focus on the utilization of baccalaureate prepared registered professional nurses to deliver nursing care.

Page 53

The fourth paragraph is nonsensical. Is there a valid observation being made? Also, if so, by whom? NYSNA requests removal of the last sentence from the report.

Page 56

Please produce the documentation regarding the enrollment demographics.

Page 57

The analogy between the shared areas in scopes of practice between RNs and MDs to the relationship of an aide to a supervising nurse is incredulous! There are entirely different levels of responsibility and knowledge involved in these relationships.

The first sentence in the next paragraph makes absolutely no sense. Also, NYSNA agrees that it is unusual, if not totally inappropriate, to include a personal anecdote of five paragraphs in this Report. NYSNA requests its removal.

Page 58

The practice being alluded to in paragraph five is potentially illegal.

Page 61

Clarify the use of "outstripped" in paragraph 5.

Page 63

Where is the data to support "part-time, by choice?"

Page 65

In paragraph 3, are sentences 5 and 6 meant to be "cause" and "effect." If so, where is the supporting data?

Page 67

NYSNA regrets that the Task Force does not recommend an increase in the dollar amount of Regents Nursing Scholarships. This amount is definitely part of the problem, not the solution. Also, it appears that the Regents Professional Opportunity Scholarships Program dropped nursing in 1987-88 and there are currently no plans to include the profession in 1988-89. This must be immediately corrected and monies appropriated in the Executive Budget.

Page 72

The quote in paragraph one is inaccurate and misleading. Documentation has been given to Mr. Salsberg.

Page 74

NYSNA objects to the unsubstantiated conclusion that "great numbers of RNs are believed to work part-time ..."

V. Projections

Page 80

Since RNs have associate, baccalaureate and masters degrees, this information must be included in this table.

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VI. Alternative Service Approaches

This is an interesting and substantive discussion.

VII. Recommendations

Page 127

1. The first sentence of the third paragraph belongs in the second paragraph. The next sentences should read:

> Work in the health care industry has always included the danger of contracting contagious diseases. The current HIV epidemic, increased incidence of TB and prevalence of Hepatitis B create potentially new dangers and stresses for health care workers.

2. The first sentence in paragraph 4:

> Registered professional nurses, who have been involved in direct patient care for many years, do not have a significantly higher financial compensation than entry-level nurses.

Page 128

Add to G - There should be a direct incorporation of patient acuity/nursing intensity into the reimbursement methodology which will provide the incentive and resources to improve nurses' salaries and benefits.

Page 130

In B-3, please specify in what type of educational facility these programs will be offered.

Page 131, A & B

While the language in the job redesign program has been modified, NYSNA still believes that there is the potential to permit institutional licensure as a method of determining nursing practice. Therefore, any job redesign demonstration projects which would involve nursing practice will require close scrutiny and monitoring. Also, NYSNA strongly objects to periodic reassessment of scope of practice requirements which we assume will include a review of professional practice acts with the ever present potential for inappropriate changes in the acts.

Page 132

In H-2, NYSNA would suggest that the most appropriate and reasonable manner to standardize the curriculum of LPN programs would be to

require an associate degree education. Thus, with a standardized curriculum, one could more reasonably address the ongoing scope of practice questions.

Page 134

In A-1-a, the suggestion for LPN education to be expanded in the high schools is ludicrous. How can we expand scope of practice, when the educational base is reduced to a minimum?

In conclusion, the New York State Nurses Association would like to comment on the not-so thinly veiled negative and disparaging comments sprinkled throughout the Report with regard to professional organizations. One is motivated to query - "What is wrong with any or a particular professional organization?"

Individuals, and that includes professionals, have the civil right to form a group to meet their special needs. Professional groups reflect the individual and collective ideas and attitudes of its members. There is nothing ethically or morally wrong with this. Professional nursing organizations have long been the leaders in establishing standards of nursing care which are both guides for its members and quality assurance mechanisms for the public.

There is probably not a single member of the Labor-Health Industry Task Force who does not represent a special interest. In fact, the reason for bringing this group together was to have many "interests" organized in seeking solutions to a complex problem. Why than does this Report need to scapegoat the professional organizations?

The New York State Nurses Association, the nation's first state nurses' association, will always be proud of its long tradition of representing the profession of nursing to the people of the State of New York and assuring high standards of patient care.

Sincerely,

Karen A. Ballard

Karen A. Ballard, MA, RN
Director
Nursing Practice and Services Program

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